No. 18,272

United States Court of Appeals

For the Ninth Circuit

GRACE TURNER,
Appellant,

vs.

THE MANHATTAN LIFE INSURANCE COMPANY, a New York Corporation,
Appellee.

Appeal from the United States District Court for the Northern District of California, Southern Division

OPENING BRIEF OF APPELLANT

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I

PLEADINGS AND FACTS DISCLOSING THE BASIS OF JURISDICTION OF THE DISTRICT COURT AND THE JURISDICTION OF THE COURT OF APPEALS TO REVIEW THE JUDGMENT IN QUESTION

(1) Statutory Provisions Sustaining Jurisdiction.

(a) Jurisdiction of District Court.

The action is a suit by a California resident to recover from a New York Corporation proceeds of a life insurance policy in an amount of twenty-five thousand dollars ($25,000).

Title 28 U.S.C. 1332. Diversity of citizenship; amount in controversy:

> "(a) The district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and is between—
>
> (1) citizens of different states;"

(b) Jurisdiction of Court of Appeals.

Judgment was entered by the District Court in favor of the Defendant and against the Plaintiff. Judgment was entered July 10, 1962. Notice of appeal was filed by Plaintiff August 9, 1962.

The judgment being final and timely notice of appeal having been given this Honorable Court has jurisdiction to review the judgment under the provisions of 28 U.S.C. 1291-1293.

(2) The Complaint.

The complaint alleges the corporate existence of the defendant pursuant to the laws of the State of New York (Transcript of Record, p. 11), and the amount in controversy to be the sum of $25,000. (Transcript of Record pp. 12, 13.) The complaint was filed in the Superior Court of the State of California and was removed to the United States District Court pursuant to Petition for Removal filed by defendant (Transcript of Record p. 6) setting forth the California citizenship of plaintiff. (Transcript of Record p. 7.)

II

STATEMENT OF CASE, QUESTIONS INVOLVED AND MANNER RAISED

The action below was instituted to collect the proceeds of a policy of life insurance following the death of the insured. The defense of misrepresentation of the physical condition of the insured at the time of application for insurance was interposed by the answer. The judgment in favor of the defendant as predicated upon the findings determined that the defendant was entitled to rescind the contract of insurance by reason of misrepresentations of the insured. The basic questions involved in the appeal are the sufficiency of the findings as to misrepresentation, falsity, knowledge of falsity, reliance, the right of the insured to rely upon the representations, the diligence of the insurer, the admission of incompetent evidence and the failure of the Court to give due weight to basic presumptions of law. The questions are raised by a direct appeal from the judgment of the District Court.

III

SPECIFICATION OF ERRORS

(1) The evidence does not support the findings that the answer of the decedent to each of the following questions was false and was known by Andre at the time it was given to be false:

No. 19—whether he had ever been hospitalized;

No. 16(a)—whether he had ever suffered from any ailment or disease of the brain;

No. 16(b)—whether he had suffered from any ailment or disease of the blood vessels. (Finding 5.)

(2) The evidence when weighed with the applicable presumptions of law does not support the finding that false answers to each of the questions referred to were knowingly made in bad faith by the insured. (Finding 8.)

(3) The evidence does not support the finding that the defendant relied upon the representations of the insured in the issuance of the policy. (Finding 11.)

(4) The evidence does not support the finding that the defendant would not have issued the policy on Andre's life had it been aware of the true facts concerning his physical condition. (Finding 11.)

(5) The District Court erred in concluding that the defendant did not waive its right to know the facts and did not neglect to make inquiry as to the truth of representations. (Conclusion of Law 3.)

(6) The District Court erred in admitting into evidence against a beneficiary of an insurance policy with a vested interest, declarations of the decedent not made at the time of the procuring of the policy, and not part of the res gestae (Reporter's Transcript, p. 16, l. 9; p. 22, l. 12; p. 23, l. 3; p. 23, l. 12; p. 28, l. 21 to p. 30, l. 2; p. 31, l. 24 to p. 32, l. 11; Order of Court on Objections, Tr. p. 49-50.)

(7) The District Court erred in admitting into evidence the testimony of the Medical Officer of defendant who had evaluated the risk, that the defend-

ant would not have assumed the risk had different answers been given in the application of the insured. (La Pointe Deposition—Rep. Tr. p. 48, l. 21 to p. 51, l. 19; Order of Court on Objections, Tr. pp. 49-50.)

(8) The District Court erred in admitting into evidence the records of the Presbyterian Hospital relating to an illness occurring subsequent to the issuance of the policy. (Rep. Tr. p. 19, l. 1 to l. 21; Order of Court on Objections, Tr. pp. 49-50.)

(9) The District Court erred in giving to the representations made in the application for insurance the weight of warranties, contrary to the express provisions of the policy. (Exhibits A and B for Defendant.)

(10) The District Court erred in concluding that the Defendant was entitled to rescind the policy.

IV

ARGUMENT

STATEMENT OF FACTS

On January 20, 1959, Noble Andre made application to The Manhattan Life Insurance Company for a policy insuring his life in a requested amount of fifty thousand dollars ($50,000). The applicant was not unknown to the defendant. In March of 1958 a trial application had been submitted to Manhattan to test the insurability of Andre. (Rep. Tr. pp. 65-66.) To such trial application was attached a report of a physical examination of Andre made on behalf of

Pacific Mutual Life Insurance Company by Doctor David Leigh Rodgers on July 27, 1956. A portion of the application made to Pacific Mutual in 1956 was also attached to the trial application submitted to Manhattan in 1958. (Rep. Tr. p. 66.) The material so supplied to Manhattan in 1958 revealed that the applicant had been "rated" by Pacific Mutual in 1956, had been declined by another insurer because of EKG findings and had EKG tracings suggestive of past myocardial damage. (Exhibits La Pointe deposition.) There was further submitted with the 1958 application an electrocardiograph taken December 26, 1957. (Rep. Tr. p. 68, Exhibit La Pointe Deposition.)

The 1958 application to Manhattan related to the proposed issuance of a policy in the amount of $100,000. Review of the application by L. Gordon La Pointe M.D., Medical Director of Manhattan, resulted in a qualified commitment for only one-fifth of the amount of insurance applied for and that at a Class F rating. The observation of the Medical Director was that "the applicant's status is worse than in August 1956." (Rep. Tr. p. 68.) The 1958 commitment for the reduced amount at a rated classification was not acceptable to Andre.

By reason of the state of the record and knowledge already in its possession the defendant, upon receipt of the application of January 1959, subjected Andre to special examinations including x-rays and electrocardiograms not normally undertaken in an application of the nature of that being processed. (Rep. Tr. p. 75.) Andre was examined by Doctor David Leigh

Rodgers, the same physician who had conducted the 1956 examination on behalf of Pacific Mutual and whose findings had been the cause of a "rated" classification.

The 1959 examination by Dr. Rodgers was made conjointly for the benefits of both Manhattan and Pacific Mutual by reason of simultaneous applications filed with the two companies by Frank Crooks, the agent who was eneadvoring to sell insurance to Andre. (Rep. Tr. p. 72.) Manhattan was aware of the concurrent Pacific Mutual application and made a notation in its records to watch the outcome of the Pacific Mutual action upon such application. (Rep. Tr. pp. 73-74.) Pacific Mutual declined coverage and Manhattan was so advised. (Rep. Tr. p. 74.)

The 1959 application to Manhattan disclosed that the applicant had been "rated" by Pacific Mutual in 1956 and had been declined by Canada Life in 1956. The application also named Dr. Holliger as a physician by whom Andre had been treated within a period of five years and revealed that an electrocardiogram had been taken by such physician. (Exhibit B in evidence.) Written authorization was given to Manhattan by Andre affording access to his medical records and to information respecting his physical condition. (Exhibits La Pointe deposition.) Correspondence was had between Manhattan and Doctor Holliger. (Exhibits to La Pointe deposition and to Holliger deposition.)

Manhattan was a member of the Medical Information Bureau, a clearinghouse of medical information

on insurance applicants. Upon review of the x-ray and electrocardiogram Manhattan reported to the M.I.B. that the x-ray showed an amount of enlargement and that the electrocardiogram disclosed an unusual T wave and a peculiarity of the S-T interval. (Plaintiff's Exhibit last in order.)

Upon consideration of the application Manhattan decided to issue only one-half of the amount of insurance requested and to charge an extra annual premium of $375 for three years in addition to a special class rating. A policy in the face amount of $25,0000 issued upon such basis bearing date of February 7, 1959, and was delivered March 20, 1959. A premium of $1819.00 was paid for the first year and a like premium was paid March 3, 1960. (Pre-trial Order.) The limitation of the amount of insurance, the increased premiums and the special class rating were predicated upon the physical condition and history of Andre. (Letter La Pointe March 3, 1959, Exhibit to La Pointe deposition.)

The policy designated Andre Paper Box Company, a corporation, as beneficiary. The premiums were paid by, and all rights of ownership resided in, Andre Paper Box Company.

Noble Andre died March 18, 1960. Due proof of loss was submitted to the defendant. (Answer paragraph I.) The insurer gave notice of rescission of the policy by letter dated June 20, 1960 "because of misrepresentations material to the risk made by Noble Andre in his application." The claimed misrepresentations may be generally classified as a concealment of a hos-

pitalization for a period of 48 hours for observation for a possible cardio-vascular accident and misrepresentations relating to the condition of the heart.

The District Court found grounds for rescission.

(1) The Evidence Does Not Support the Findings That the Answers of the Decedent to the Questions Relating to Hospitalization, Brain and Blood Vessels, Were False and Were Known to Be False.

The composite finding numbered 5, relates to three questions appearing in the written application signed by Noble Andre on January 20, 1959. The District Court found that the answer to each question was false and was known by Andre at the time given to be false. The finding that Andre had given an answer false, and known at the time to be false, to the question "whether he had ever been hospitalized" is predicated upon a negative answer to question 19. The basis for the finding was an episode occurring October 22, 1958 wherein a sudden dizziness and speech difficulty prompted Doctor Holliger to place Andre in Hahnemann Hospital in San Francisco for observation from 3:05 P.M. on such day to 3:44 P.M. on October 24, 1958. The stay was uneventful. On October 23 Andre went to Children's Hospital where an electroencephalogram was taken with negative results. On October 24 Andre was "ambulatory as desired." He was "dismissed walking." (Deposition and exhibits, Mary Moran.) The episode was hardly one which would make an indelible impression nor one which an applicant would be tempted to conceal. The tests were negative and Doctor Holliger's subsequent

appraisal was "it might be my impression he may have a vasospastic—in other words, spasm of the blood vessel rather than actual injury to the blood vessel itself." (Holliger Deposition, p. 51, ll. 21-23.) The doctor apparently did not consider the matter of sufficient importance to give it mention in his letter to the insurance company concerning Andre's physical condition. (Holliger Deposition, p. 51, l. 24.)

Apart from the absence of necessity for an applicant to conceal such fact, the impossibility of doing so must have been apparent to a man of Andre's intelligence. The hospital record was available; the incident was recited in the records of Doctor Holliger; and Andre had given written authorization to Manhattan to examine his records and consult his doctor. The records of his medical insurance carrier were also available revealing his claim for hospitalization benefits. Why then was a negative answer given to question 19? A reading of the question will supply the reason. The question is so ambiguous that it cannot be ascertained therefrom that the inquiry relates to the mere status of being a patient in a hospital. Question 19 reads:

> "19. Have you ever been an inmate of, or received treatment or cure at an asylum, hospital, or sanitarium?"

Appellant contends that the question is so misleading that it does not suggest the circumstance of admission to a hospital. The words "inmate", "cure", "asylum" and "sanitarium" connote a mental disorder or some abnormality. The reference to "hospital"

is masked and obscured by the remainder of the question. It certainly is not tantamount to an inquiry as to whether the applicant had ever been hospitalized. The ambiguity is of the making of the defendant and in accordance with the well settled policy of law the uncertainty and ambiguity is to be interpreted most strongly against the insurer. (California Civil Code 1654; *Witherow v. United American Ins. Co.,* 101 C.A. 334; *Everett v. Standard Accident Insurance Co.,* 45 C.A. 332.) The ambiguity here found is much more gross than that encountered in *Newton v. S.W. Mutual Life Assn.,* 116 Iowa 311, 90 NW 73, wherein the question "Has any company ever declined to grant insurance on your life?" was held to be too vague to require an applicant to state that he had been declined by the Woodmen of the World. The Court in the *Newton* case admonishes us:

> "If any construction can reasonably be put on the question and the answer such as will avoid a forfeiture of the policy on the ground of falsity of the answer, that construction will be given, and the policy will be sustained."

The negative answer to the question whether he had ever suffered from any ailment or disease of the brain was found objectionable by the Court below.

In the light of the requirement of the application that the answers be true "to the best knowledge and belief" of the applicant it is difficult to condemn such answer as "false" and "known to be false". The dizziness and temporary speech difficulty encountered

in October of 1958 was not a basis for Andre to conclude that he was afflicted with an ailment or disease of the brain, when he had been presented with a negative encephalogram, when the condition had quickly cleared (Holliger deposition p. 33, ll. 10-26) and when he had the reassurance of a doctor's opinion that it had possibly been caused by a "spasm". (Holliger deposition p. 51, ll. 21-23.)

The answer to the question relating to a disease or ailment of the blood vessels must also be appraised in the light of the circumstances existing on January 20, 1959 and not be viewed in connection with a subsequent history or inquest. The applicant had never had high blood pressure, despite an erroneous indication in the records of Hahnemann Hospital. (Holliger deposition p. 41, ll. 22-23.) Whatever vascular problem may have been suspected at the time of the hospitalization was not of such a nature as to give the doctor cause for alarm. Dr. Holliger refers to a "little" rupture (p. 30, l. 26 Holliger deposition), the involvement of a "small" artery (Holliger deposition p. 31, l. 8), the "impression" of a "small CVA" (Holliger deposition p. 30, l. 23) and finally the impression of a "spasm of the blood vessel rather than actual injury to the blood vessel itself". (Holliger deposition p. 51, ll. 22-23.) It was the practice of the doctor to keep his patient informed (Holliger deposition p. 34, ll. 13-17) and we must assume that the information and opinions given to the patient would be no different than what was known and believed by the doctor himself.

There is no finding of falsity or intentional misrepresentation respecting any specific question relating to the heart. But from the finding (7) which recites the existence of symptoms and the advice of the doctor that such symptoms evidenced angina pectoris we must assume that the Court decided that the questions relating to the heart were falsely answered. It is undeniable in retrospect that a heart condition existed at the time of the application. But the law is well settled and most logical in its position that falsity cannot be demonstrated by subsequent events. (*Brubaker v. Beneficial Life Insurance Co.,* 130 C.A.2d 340; *Chase v. Sunset Mutual Life,* 101 C.A. 625.) We are here concerned with the then state of the record and Andre's best knowledge and belief as to his condition. Obviously his knowledge and belief were those of his physician as communicated to him. The deposition of doctor Holliger discloses diagnoses and opinions which would support the answers of the decedent to all of the questions of the application. An over-all optimism as to the condition of the patient pervades the deposition. At page 22, line 21, the doctor reassures the patient and tells him "not to be alarmed" because of a refusal of insurance. At page 28 at lines 14 and 16 the doctor refers to the "heart pain" episode as "impressions" and comments on line 20 "you may note that is the first time of any complaint of that," and commencing at line 26 of page 28 "the only notation we have of any difficulty there was in '57. There was no notation, there were no complaints after that time." On page 29, lines

3 through 8, the doctor again questions his working diagnosis of angina pectoris. When asked if, at and about the time of the Hahnemann Hospital visit Andre was taking medicine for a heart condition the doctor stated that he had neither prescribed nor asked the applicant to take medication. (p. 36, l. 25 to p. 37, l. 8.) The notes of the doctor for December 29, 1958 state: "Doing OK—no problems," and for February 6, 1959 "no problems. Reflexes okay." The reassurances given Andre by Doctor Holliger are comparable to those which the Court found to be persuasive of good faith in *Ransom v. Penn Mutual Life Ins. Co.* (43 C.2d 420).

On pages 50 and 51 of his deposition the doctor generally reviews his treatment and findings respecting the insured. He states in part (p. 50, l. 9):

> "Also I wish to note that he has no complaints from '39 up to . . . the time that he was last in this office, except for the one occurrence,"

and (p. 50, l. 14):

> "I will state this again: That at the time we made the diagnosis, December 30th, 1957, of one angina and coronary insufficiency, that this was our *impression* at that time."
>
> "Now, also let me state that whenever we take care of a patient with any symptom of chest pain, we'll always assume that it's the worst, and we'll treat them and put them under treatment for the worst possible condition that they could have."

As part of the processing of the application of January 20, 1959, Manhattan availed itself of the

authorization given by Andre and communicated with Doctor Holliger. The reply of the doctor (letter dated February 16, 1959, exhibit to La Pointe and Holliger depositions) states:

> "I have insisted on seeing Mr. Andre at regular intervals, but I have failed to demonstrate any cardiac disease."

The letter represents the doctor's appraisal of Andre's condition at the time of the application—his best knowledge and belief as the result of observations made over a period of ten years. That subsequent events proved both doctor and patient wrong is no evidence of bad faith or misrepresentation. What was represented was the best knowledge and belief of both—all that the application required—and all that the law demands.

(2) The Evidence, When Weighed With the Applicable Presumptions of Law Does Not Support the Finding That False Answers to Each of the Questions Referred to Were Knowingly Made in Bad Faith by the Insured. (Finding 8.)

Review of the evidence fails to fully support the objective findings as to the incorrectness of the representations made let alone the subjective findings as to knowledge and bad faith. As contended above, the facts taken alone do not warrant the conclusions made. They become wholly inadequate when considered in the light of the presumptions afforded by law.

By attempting rescission upon the ground of fraud the Insurer has taken upon itself the burden of proving an affirmative defense and overcoming a

presumption of law against fraud. As stated by Justice Lemmon in *Canada Life Assurance Company v. Houston* (9th Circ.) 241 F.2d 523:

> "In a case of this kind, the insurance company has the burden of proving fraud. As was said in *Truett v. Onderdonk* (1898) 120 Cal. 581, 588; 53 P. 26, 29, 'the presumption is always against fraud—a presumption approximating in strength that of innocence of crime'."

Little, if any, weight could have been given to this presumption if bad faith is deduced from such inconclusive facts. In view of the circumstance that all of the representations as to physical condition stem from and parallel the assurances and opinions of the doctor, conspiracy as well as bad faith must have been concluded. The difficulty experienced by the broker in selling insurance to Andre would also argue against a finding of fraudulent intent to obtain insurance. (Rep. Trans. p. 75, l. 22 to p. 76, l. 1.) The evidence from which a finding of bad faith has been drawn is too tenuous and too contradicted to offset the presumption against fraud.

(3) The Evidence Does Not Support the Finding That the Defendant Relied Upon the Representations of the Insured in the Issuance of the Policy. (Finding 11.)

The finding that the defendant relied upon the representations of the insured in issuing the policy disregards so many obvious facts as to be almost naivete. If the objectionable answers to certain questions in the application constituted the basis for the issuance of the policy what is there to justify the limitation

in the amount of insurance, the "rated" classification and the stepped up premium above and beyond the rated base. There is nothing in the "relied upon" application which would warrant such treatment.

> "It is a fundamental principle of the law of fraud that in order to secure redress, the party must have relied upon the statement or representation as an inducement to his action. The logical consequence of this rule is that the representee in order to render the representations actionable, must have been deceived by them, since the law will not permit one to predicate damage upon statements which he does not believe to be true." (169 A.L.R. 361).

There is no other interpretation of this record than that the insurer took a known and calculated risk. The policy in litigation is not a contract entered into by an unsuspecting insurer with a pristine prospect. We are here dealing with an acknowledged sub-standard risk upon damaged merchandise.

The defendant concedes that this contract was a "sub-standard risk" by designedly failing to reply to number (1) of Plaintiff's Request For Admission of Facts (Trans. p. 42). The acquaintanceship of the defendant and the insured was almost intimate. From an application filed with it in 1958 Manhattan knew that Andre had been rated in 1956 by Pacific Mutual Life Insurance Company and had been declined by another insurance company by reason of electrocardiogram findings. (Exhibit to La Pointe deposition.) With the record of past myocardial damage revealed by the records submitted in connection with the 1958

application the defendant requested and received of Doctor Holliger an electrocardiogram tracing of December 26, 1957 and concluded therefrom that the status of the applicant in 1958 was worse than in August 1956. (Exhibits to La Pointe deposition.) Suspicions of heart condition were well implanted in the records of Manhattan when the 1959 application of Andre came before it. Forearmed, it directed Doctor David Leigh Rodgers to subject the applicant to special tests, a chest x-ray, and an electrocardiogram, not normally given in connection with an application of the size being processed. (Rep. Tr. p. 75, ll. 4-21.) Significant also is the fact that Andre was no stranger to the examining physician. Doctor Rodgers had examined him in 1956 on behalf of Pacific Mutual and his findings had resulted in a "rated" policy. (Exhibit to La Pointe deposition.)

Even less convincing is the claim of reliance when it becomes obvious that the questions in controversy are answered in the handwriting of Dr. Rodgers, an agent of the insurer with a knowledge of facts inconsistent with the answers. (Exhibit B in evidence.)

Such facts would make it apparent that the answers complained of were not taken at face, or at any value. The conduct of the insurer confirms the point. When informed that a simultaneous application was being considered by Pacific Mutual predicated upon the same medical examination made by Doctor Rodgers, the defendant made a "target" of the companion application so as to have the benefit of Pacific Mutual's appraisal of the risk. (Rep. Tr. p. 73, l. 23 to p. 74,

l. 19.) Yet the adverse action of Pacific Mutual did not deter Manhattan from accepting the risk—inasmuch as Andre Paper Box Company had the financial responsibility to meet a stepped up premium. The real concern of Manhattan is indicated by its conduct in engaging the Retail Credit Company to investigate the financial stability of the applicant but not bothering to use the authorization given it by Andre to consult Doctor Holliger's records despite information giving real cause for suspicion of heart trouble. The correspondence and the EKGs of Doctor Holliger evidenced the concern of the applicant's physician as to the possibility of a heart problem. The disclosure that Canada Life Assurance Company had declined coverage by reason of cardiograph readings brought forth no inquiry as to what such files might contain. The report which Manhattan made to the Medical Information Bureau April 13, 1959 clearly shows that there was no misapprehension as to the quality of the commodity with which it was dealing—the analysis of the chest x-ray showed an amount of heart enlargement and the EKG taken by Doctor Rodgers on January 20, 1959 was described "T. wave unusual, peculiarity of S-T interval." (Plaintiff's Exhibit last in order.)

The answer of the defendant to interrogatory 16 propounded by plaintiff (Tr. pp. 28 and 31) concedes that it did not rely solely upon the representations made in the application. Answers to interrogatories 17 and 18 reveal that the company issued the policy in a reduced amount and at an increased premium

rate because of knowledge which it had from sources other than the application and which was contrary to the answers in the application.

The record is replete with facts which belie the purported reliance upon the questions of the written application. It is obvious that the insurer made its own appraisal of the health of the applicant, increased the premium to make the risk worthwhile, guessed wrong, and is now backing down on its undertaking with a claim of "foul."

As in *Weir v. New York Life Ins. Co.*, (91 C.A. 222, 230) the insurer knew of facts contrary to the representations in the application before issuing the policy and "issued it in a reduced amount and at an increased premium rate because of its knowledge."

(4) The Evidence Does Not Support the Finding that the Defendant Would Not Have Issued the Policy on Andre's Life Had It Been Aware of the True Facts Concerning his Physical Condition. (Finding 11.)

If there were any facts which the defendant did not know relative to the physical condition of the applicant such ignorance was self-induced. The attempt to hide behind a questionnaire which defendant knew was not even filled out by the applicant is most unconvincing. The insurer had ample warning of the risk involved, made a thorough examination on its own behalf, decided to issue the policy on a remunerative basis and then closed its mind to any further consideration of the matter. Its refusal to consult Pacific Mutual after the unfavorable action of such company upon the 1959 application is most indicative.

If any special circumstances existed which were known to Pacific Mutual, they were of no interest to Manhattan.

At all times this insurer could have declined coverage as others had done upon the same information possessed by Manhattan but despite knowledge sufficient to urge caution it persisted with the contract in the hope of monetary advantage. From the 1958 application it knew that Andre could not be forced to extremes and that the offer had to be made more attractive than the 1958 offer which Andre refused. The rating and policy limit of the 1959 contract are slightly better than the 1958 offer.

The conduct of the insurer in disdain of other possible facts is the most eloquent evidence pertaining to the portion of Finding 11 falling within the "had I known" category. The only other evidence purporting to touch upon this negative feature is the incompetent and self-serving statements of the company's medical officer which will be considered under a subsequent heading and the abstract testimony of Doctor Robbins who assumed that the only information in the files of the insurer was what was contained in the application and who had very limited experience in evaluating insurance risks (Rep. Tr. p. 91, l. 20 to p. 93, l. 3.) The inadequacy of Doctor Robbins' opinion may be demonstrated by his interpretation of the electrocardiogram taken by Doctor Rodgers on January 20, 1959. Doctor Robbins read the tracings as indicating a trend toward normal when compared with the tracing of December 1957.

The same electrocardiogram of 1959 prompted Pacific Mutual to reject the risk and caused Manhattan to comment upon the "unusual T. Wave" and the "peculiarity of S-T interval." (Plaintiff's exhibit last in order.)

The general inadequacy, if not irrelevancy, of Doctor Robbins' testimony is apparent from a full reading of the transcript. It is apparent that the Doctor is unaware that the hypothetical questions relate to an insurer dealing in sub-standard risks and that the problem is one relating to a sub-standard contract with a person well known to the issuer. He is apparently unfamiliar with "rated" policies and obviously was not informed that "uninsurable" persons are covered if the price is right.

The most vital and an invalidating objection to the testimony of Doctor Robbins is that it is predicated upon a false hypothesis. The questions posed assumed that Andre had sustained a cardiovascular accident and that he had experienced recurring chest pains during the year 1958. (Rep. Tr. p. 84, ll. 24-25; Rep. Tr. p. 86, l. 23.) In comparing the 1957 and 1959 cardiograms the doctor was under the impression that there was a history of recurring difficulty during the intervening period. This is contrary to the facts in evidence. The chest pain episode antedates the 1957 cardiogram and there is absolutely no evidence of any recurring pains during 1958. The testimony of Andre's attending physician, the only evidence on these matters, proclaims that in his best judgment, as of the time of the application, there was insuffi-

cient indication of a cardiovascular accident to support such a diagnosis, and that the 1957 chest pain attack was the only incident of such nature from 1939 until the last visit of Andre to the doctor's office, February 6, 1959. (Holliger deposition p. 28, l. 26 to p. 29, l. 2; p. 50, ll. 9-11.)

(5) The District Court Erred in Concluding That the Defendant Did Not Waive Its Right to Know the Facts and Did Not Neglect to Make Inquiry as to the Truth of Representations. (Conclusion of Law 3.)

The law will not permit an insurer to remain passive when it is in possession of information which should give cause to question the advisability of the risk which it is undertaking. The information in the possession of the defendant was a factor warranting the application of the doctrine of *Di Pasqua v. California Life Insurance Company,* 106 C.A.2d 281, placing upon the insurer the duty of further inquiry to ascertain the pertinent facts. The substantial record of Andre's heart condition warned Manhattan that answers in the questionaire were inaccurate. As stated by the Court in *Di Pasqua*:

> "The company was put upon notice prior to issuance of the policy that the answers of the insured could not reasonably be relied upon."

The written authorization from Andre to Manhattan affording access to the records of Doctor Holliger is a further fact in common with the *Di Pasqua* situation wherein the Court critically pointed out:

> "It had in its possession an authorization signed by the insured to obtain any medical information pertaining to him."

By its decision the Court there imposed upon the insurer the duty of exercising the authorization.

Circumstances present in the case here under consideration gave to Manhattan additional sources of information even more readily available. Manhattan was aware that Pacific Mutual had once rated and had then declined Andre and that Canada Life had refused him coverage. Yet no inquiry was made of either company to learn if such actions were predicated upon facts not known to Manhattan. The files of Manhattan further disclose a customary source of insurance information unavailed of. Membership in the Medical Information Bureau (Rep. Tr. p. 69 and exhibits La Pointe deposition) entitled Manhattan to receive the benefit of the files of all other insurers who had examined Andre. Manhattan transmitted what information it had evolved but asked for none. In the case of *Columbian National Life Insurance Co. v. Rodgers*, 116 F.2d 705, the Court held that information in the possession of an M.I.B. member prior to the issuance of a policy that an application had been made to another company and that such company had created a record was sufficient to put the insurer on inquiry.

The failure of Manhattan to explore any of the sources of information available to it gives further support to the contention of appellant that the appellee made its own examination, evaluated the risk and was not interested in the conclusions of others or in additional data. By its lack of diligence or obstinacy Manhattan foreclosed the right to claim it was misled by representations in the application.

(6) The District Court Erred in Admitting Into Evidence Against a Beneficiary With a Vested Interest, Declarations of the Decedent Not Made at the Time of Procuring the Policy and Not Part of the Res Gestae.

In the records of Hahnemann Hospital introduced through the deposition of Mary Moran and also incorporated in the depositions of Doctor Holliger and Doctor La Pointe are notations derived from declarations made by Andre. (Rep. Tr. p. 16, l. 9-13; page 3 of Hahnemann record.) Prescinding from the inaccurate reference to high blood pressure, which Andre did not have (Holliger deposition p. 41, l. 22) the history purports to be a recitation of statements made by Andre at the time of the admission to Hahnemann Hospital.

In the deposition of Doctor Holliger and in exhibits thereto are notations of conversations between the doctor and Andre purporting to record statements of Andre. (Rep. Tr. p. 28, l. 21 to p. 30, l. 2; p. 31, l. 24 to p. 32, l. 11—page 20 of Holliger records.)

In the exhibits to the Tuxbury deposition are found histories and a summary quoting or paraphrasing declarations of Andre. (Rep. Tr. p. 22, l. 12; p. 23, l. 3; p. 23, l. 12.)

Objection was duly made to the introduction of any of such evidence and the objections were overruled by the Order of Court on Objections. (Tr. pp. 49-50.)

The basis for the objections is that declarations of Andre not made at the time of the application for insurance and not forming a part of the res gestae of such transaction are inadmissible against the appellant as assignee of the owner-beneficiary of the

policy who held a vested interest. The principle of law supporting such objection is set forth in 29A *Am. Jur.* 944 § 1885:

> ". . . where the defense in an action on a contract of life insurance is based on the alleged falsity of statements contained in the application, admissions or declarations of the insured, whether made before or after the policy was issued are not admissible against a beneficiary, other than the estate of the insured, unless they were part of the res gestae."

California decisions support such rule. In *Yore v. Booth*, 110 Cal. 238, the insurer sought to introduce other applications made by the deceased which controverted the age represented in the application before the Court. It was held that any declarations of the deceased, not made at the time of procuring the policy, or as part of the res gestae, were hearsay and incompetent.

In *Jenkin v. Pacific Mutual*, 131 Cal. 121, declarations made by the deceased before his death tending to show that he contemplated suicide were held not competent evidence.

In *Paez v. Mutual Indemnity*, 116 Cal.App. 654, 661, the Court gave approval to *Yore v. Booth* and concluded:

> "In the instant case any statement made by the deceased after the issuance of the policy was not part of the res gestae and not binding on the plaintiffs herein and therefore not admissible."

The California decisions are crystallized in 28 *Cal. Jur.* 2d 379 § 608:

"Declarations of a decedent not made at the time of procuring a life insurance policy or as part of the res gestae are hearsay and incompetent as evidence against beneficiaries who have a vested interest in the policy." (*McEwen v. New York Life,* 42 C.A. 133.)

(7) The District Court Erred in Admitting Into Evidence the testimony of Doctor La Pointe That the Insurer Would Not Have Assumed the Risk Had Different Answers been Given in the Application.

Through the deposition of Dr. La Pointe the defendant would have us believe that had one or two questions in the application been answered differently it would not have issued the policy. (Rep. Tr. p. 48, l. 1 to p. 51, l. 19; Ruling—Tr. pp. 49-50.) In order to meet this issue head-on we will prescind for the moment from the lack of diligence on the part of defendant which kept it from ascertaining the information now purported to be so vital. Then let us first recall that Dr. La Pointe is the Medical Director of the defendant and is the ultimate judge of the insurability of applicants for life insurance. (La Pointe deposition p. 2.) Any testimony from this source that the policy would not have issued had he been apprised of other facts is an infringement upon the prerogative of the Court. Whether the facts allegedly concealed were of such import as to compel different conduct if known is a matter for judicial determination. Plaintiff recognizes that there is a conflict of authority upon the admissibility of evidence that the insurer would not have accepted the risk except for the misrepresentations. The greater

weight of authority holds such testimony to be incompetent. This would seem to be the better rule in view of the obviously self-serving and subjective nature of the testimony and the difficulty of controverting it. The logic of this position is well set forth in *Volunteer State Life Insurance v. Richardson,* 146 Tenn. 589; 244 S.W. 44:

> "It is not to be left to the insurance company to say, after a death has occurred, that it would or would not have issued the policy had the answer been truly given . . . no sound principle of law would permit a determination of this question merely upon the say-so of the company after the death has occurred."

It was stated in *New Era Assn. v. MacTavish,* 133 Mich. 68; 94 N.W. 599:

> "To adopt the theory of complainant (insurer) is to permit one of the parties to a contract to determine its construction.
>
> "The Insurer cannot be permitted to testify that he would not have taken the risk had he known the facts."

Other decisions supporting this viewpoint include:

Luke Grain v. Ill. Bankers, 263 Ill. App. 576;
Louis v. Connecticut Mutual, 68 N.Y.S. 683;
Mace v. Provident Life, 101 N.C. 122; 7 S.E. 674;
N. Y. Life Ins. Co. v. Carroll, 154 Okla. 244; 7 P. (2d) 440.

An opinion made pertinent by a parallel factual situation would also make the testimony of Dr. La

Pointe immaterial. In *Newton v. S. W. Mutual Life Assn.* (116 Iowa 311, 90 N.W. 73) the applicant had given a negative answer to the question "Has any company ever declined to grant insurance on your life?" The applicant had been denied coverage by the Woodmen of the World. It was determined that the question relating to "company" did not necessarily suggest the unfavorable action of the lodge. It is most comparable to the ambiguous question in the instant application which purports to relate to hospitalization. The Iowa court in construing the application against the insurer held:

> "If any construction can reasonably be put on the question and the answer such as will avoid a forfeiture of the policy on the ground of falsity of the answer, that construction will be given, and the policy will be sustained."

The Court further stated:

> ". . . if the answer complained of was not false, then it is wholly immaterial what the action of the medical director would have been had he known of facts not inquired about in the application."

(8) The District Court Erred in Admitting Into Evidence the Records of Presbyterian Hospital Relating to an Illness Occurring Subsequent to the Issuance of the Policy.

With the apparent purpose of proving false certain answers in the application of Andre, the insurer introduced through the deposition of Francis K. Tuxbury, the records of Presbyterian Hospital, in New York City, relating to a confinement of Andre occurring after the policy had been issued and delivered.

Objections to the introduction of the deposition as hearsay were made but by the Order on Objections (Trans. pp. 49-50) the records were admitted with the deletion of only the diagnoses.

The unfair import of such testimony is apparent and the law will not permit any inferences to be drawn from the subsequent occurrence of a condition denied to exist in the past. "The mere fact that the representations of the insured were proved to be unfounded by subsequent events, in the absence of fraud or deceit would not void the policy." (*Brubaker v. Beneficial Life Insurance Co.,* 130 C.A. (2d) 340; *Chase v. Sunset Mutual Life Assn.,* 101 C.A. 625.) The Court below in its order admitting the deposition into evidence states:

> "The remainder of said deposition and the exhibits offered and received therewith are admitted in evidence to show knowledge of the deceased at the time of his application for insurance." (Tr. p. 50.)

The facts of the subsequent occurrence are inadmissible to prove the objective fact of a pre-existing condition—yet they are admissible to prove the subjective fact of pre-existing knowledge of that condition!

The purpose for which admitted renders the ruling even more objectionable. The realization by Andre that he had suffered a severe heart seizure in March and that discomfort which he had experienced in the past was related to heart trouble does not establish the fact that in January Andre knew or believed that a heart condition existed. Viewed from a hospital

bed past episodes take on a significance not appreciated at the time of their occurrence. The March attack brought into focus prior circumstances, the true import of which was not apparent to Andre—nor to his attending physician who in February certified "I have insisted on seeing Mr. Andre at regular intervals but I have failed to demonstrate any cardiac disease."

(9) The District Court Erred in Giving to the Representations Made in the Application for Insurance the Weight of Warranties Contrary to the Express Provisions of the Policy.

Despite the obvious fact that the application had little or no persuasive influence upon the issuance of the policy (Defendant's answer to Interrogatory 16) the insurer has been permitted to avoid its obligation upon the pretext that it was misled by inaccurate answers to three questions in the application.

The contentions of the defendant below and the judgment of Court indicate that undue dignity was accorded to the answers. The policy in its General Provisions (Exhibit A) recites:

> "All statements made by, or by the authority of, the insured or the applicant for the issuance of this policy shall be deemed representations and not warranties."

The effect of such language is stated in *Couch on Insurance* (2nd Ed.) Vol. 7, § 37:121:

> "Where it is expressly provided that in the absence of fraud, statements made by the insured shall be deemed representations and not warran-

ties, good faith is sufficient, although the statements may have been incorrect in fact."

The California case of *Wills v. Policy Holders Life Ins. Co.* (12 C.A. (2d) 659) states the law of this state in this regard:

"The burden is on the defendant to prove that the statements of the insured contained in the application were not only untrue but that he knew they were false or at least had reasonable cause to believe they were false."

Further provisions of the insurance contract are perhaps even less demanding than the law. The application recites:

"It is agreed as follows . . . (b) That all statements and answers in the application will be complete and true to the best knowledge and belief of the undersigned;"

Under its agreement with the insured the company was asking merely the best knowledge and belief of the applicant. Such is what it was given.

(10) The District Court Erred in Concluding That the Defendant Was Entitled to Rescind the Policy.

By interposing the affirmative defense of fraud the insurer undertook a burden of proof which it has not sustained. The defendant below was thus required to present evidence establishing the fraud and all of the constituent elements of fraud. (*Weir v. N.Y. Life Insurance Co.*, 1 C.A. (2d) 516.) These elements include *all* of the following:

(1) Misrepresentation

(2) Material Fact

(3) Intent to Deceive

(4) Reliance Upon the Misrepresentation

(5) Justification for Reliance

(6) Falsity

(7) Knowledge of Falsity by Party Making Representations

(8) Damage from Reliance

Appellant has demonstrated that all of such factors are not found in this record. Many are absent. Others are too inconclusive to satisfy the burden of proof to the degree demanded to offset the presumption against fraud.

We will not attempt a full review of the points developed above. However, a few of the basic errors should be recounted. In the over-all it should be apparent that the Court below applied to the facts a standard not warranted by the nature of the transaction. An eminently successful businessman who

was not seeking insurance, who was in fact a "hard sell", was importuned by an insurance broker for a period of eight years. (Rep. Tr. P. 64, l. 3; p. 75, l. 22 to p. 76, l. 1.) By reason of indications of heart trouble the broker had experienced difficulty in placing insurance on his prospect. In his predicament the broker approached Manhattan, a company engaged in the handling of sub-standard risks. The prospect was known to Manhattan from a previous application in which it had given him a rating so poor as to make unattractive the limited and costly policy which it offered him. Information in such previous application gave such indication of a cardiac condition that upon a 1959 application the company directed its examining physician to subject the applicant to extra and special tests to determine his physical condition. The physician who examined the applicant was the same doctor who had conducted the previous examination which was the basis for the prohibitive rating. A medical check list in the form of a questionnaire was filled out as part of the examination, the answers to questions being inserted in the handwriting of the doctor aware of the suspected condition. The examination was made conjointly for the benefit of Pacific Mutual, which company refused to issue a policy. The application disclosed that another company had refused him coverage. Manhattan was a member of an organization serving as a clearing house for medical information on life insurance applicants making accessible information in the files of other companies. Manhattan processed the application, rated the applicant because of his past

history and physical condition and because of "electrocardiographic abnormalities and abnormalities on his chest x-ray" (answer to plaintiff's interrogatory 17, Tr. p. 31) and charged the insured an excess premium in addition to the charge for the rated classification. Approximately thirteen months after the policy date and after the payment of two annual premiums, the insured died. The insurer was permitted to rescind the policy upon the ground of fraud—the incorrectness of the answers to several questions in the application—one of which is too ambiguous to be considered and the others relating to a heart condition of which it was already aware.

Such facts do not afford a right of rescission. It is apparent that the Court has viewed the situation as though a prime risk insurer were dealing with a strange applicant, having before it no more information than was contained in the application.

The conduct of the insurer in the light of the information in its possession and in the light of the accessibility of further information was not compliance with the diligence which the law demands under such circumstances. The rule announced in *DiPasqua v. Western States Life,* 106 C.A.(2d) 281, placed the duty of further investigation upon Manhattan. Failure to conduct the inquiry suggested by the facts and required by law foreclosed any right of rescission which might have existed.

As evidenced by the findings, in order to justify rescission the Court was required to reject the possibility of good faith upon the part of Andre. Review

of the record gives the impression that the presumption existing at law was applied conversely. Overlooked are the facts that Andre did not seek insurance and that every answer given by him, other than the ambiguous "asylum" question has the support, qualified though it may be, of his physician. If after ten years of observation Dr. Holliger was unable to demonstrate a cardiac disease, why should a layman be presumed to know that such condition existed?

The greatest gap, however, in the evidence exists in connection with the element of reliance. Obvious is the objection that if Manhattan did rely upon the answers in the application, it had no right to, in view of the knowledge already in its possession. That it did so rely is incredible as well as unsupported by the evidence. Its own admission that it did not rely "solely" on the application, the rated policy and excess premium not justified by the information found in the application, the thorough examination of Andre conducted by Doctor Rodgers upon direction of Manhattan, the knowledge of Manhattan of facts contradictory of answers of Andre and its reluctance to pursue the avenues of additional information are eloquent testimony that there was an absence of reliance. The only evidence indicating reliance is the self-serving and incompetent testimony of the Medical Director of the insurer who originally evaluated the risk and who now asserts that "had he known" he would have acted differently, and the testimony of a Doctor of limited experience who was given even more limited information and an hypothesis without foundation in fact.

It is respectfully urged that no grounds for rescission exist, that the judgment of the District Court is contrary to the evidence and the law and should be reversed.

Dated, San Francisco, California,
February 7, 1963.

JOHN F. O'DEA,
Attorney for Appellant.

CERTIFICATION

I certify that, in connection with the preparation of this brief, I have examined Rules 18 and 19 of the United States Court of Appeals for the Ninth Circuit, and that, in my opinion, the foregoing brief is in full compliance with those rules.

JOHN F. O'DEA,
Attorney for Appellant.

(Appendix Follows)

Appendix.

Appendix

	Offered	Received	Rejected
Policy	Rep. Tr. p. 12	Rep. Tr. p. 12	
Application for Insurance 1/20/59	Rep. Tr. p. 12	Rep. Tr. p. 12	
Death Certificate	Rep. Tr. p. 13	Rep. Tr. p. 13	
Coroner's Report	Rep. Tr. p. 13	Rep. Tr. p. 13	
Deposition Mary Moran Custodian of Records Hahnemann Hospital	Rep. Tr. p. 13 to p. 17	Rep. Tr. p. 18	Order of Court Objections Tr. pp. 49-50
Deposition Francis Taxbury, Custodian of Records Presbyterian Hospital	Rep. Tr. p. 18 to p. 23	Rep. Tr. p. 23	Order of Court on Objections Tr. p. 50
Deposition Doctor Holliger and Exhibits	Rep. Tr. p. 23 to p. 34; Rep. Tr. p. 56 to p. 57	Rep. Tr. p. 34 Tr. p. 50	Rep. Tr. pp. 58-60
Deposition Alvin J. B. Tillman, M.D.	Rep. Tr. p. 34	Rep. Tr. p. 36	Order of Court on Objections Tr. p. 51
Deposition Gordon LaPointe, M.D. and Exhibits	Rep. Tr. p. 36 to p. 52; Rep. Tr. p. 53 to p. 55	Rep. Tr. p. 52 Order of Court on Objections Tr. p. 51	Order of Court on Objections Tr. p. 51
Medical Information Bureau Code and Translations	Rep. Tr. pp. 54-55; Letters John F. O'Dea and James Thacher	Rep. Tr. p. 55	